Patient Registration

Patient Name		Today's Date
Gender: ◻ M ◻ F	Birth date	Please check one: ◻ Single ◻ Married ◻ Separated ◻ Widow

Home Address			
City	State	Zip	Email Address

Cell Phone Number	Home Phone Number	Work Phone Number
Are you a full time student? ◻ YES ◻ NO	*If patient is a minor, we need Mother's birth date and Father's birth date*	
Your Employer	**Person responsible for account** (Parent if minor)	Cell Phone Number (responsible party if minor)

Your Driver license number (responsible party if minor)	Your Social Security Number (responsible party if minor)
How did you hear about our office?	**EMERGENCY CONTACT INFORMATION** Name, address, telephone number , relationship to contact
Reason for this visit	

NOTE: We respect your time and appreciate when you respect the time reserved for you. **A $35.00 cancellation fee will be charged for appointments canceled with less than 48 hours notice and missed appointments.**

Dental Insurance Information

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's name	Birth date	ID # or SS#
Insured's employer		
Insurance Co.		Group #
Insurance Co. Address		
Phone No.		

MEDICAL HISTORY

Patient Name______________________________________ Birthdate_____________ Today's Date_____________

Who is your family physician/internist? ____

FAMILY HISTORY If any blood relative has suffered from the following conditions, please indicate.

Condition	Family Member(s)	Age of Onset
Alzheimer's/ Dementia		
Cancer (please include type)		
Carotid Artery Surgery		
Diabetes		
Heart Attack		
Rheumatoid Arthritis		
Stent or Bypass Surgery		
Stroke		
Other Autoimmune Disease (please explain)		

YOUR PRESENT AND PAST HEALTH CONDITIONS

Have you ever had, or do you have:

☐ Auto-Immune Disease ☐ Dementia ☐ Heart Attack ☐ Heart Blockage ☐ Stroke

Direct Causes of Disease:

☐ High Blood Pressure ☐ High Cholesterol

Major Root Causes of Disease:

☐ Diabetes ☐ Periodontal Disease ☐ Sleep Apnea ☐ Smoking

Other Diseases Associated with Vascular Disease:

☐ Anxiety
☐ Breast Cancer Treatment
☐ Erectile Dysfunction
☐ Gout
☐ High Adrenaline Career (i.e.: Policeman, Fireman, etc.)
☐ History of Preeclampsia
☐ Kidney Disease
☐ Lupus
☐ Migraine Headache
☐ Polycystic Ovaries
☐ Psoriasis
☐ Restless Leg Syndrome
☐ Retinopathy
☐ Rheumatoid Arthritis

Have you been told you need to take antibiotics before dental work? ☐ Yes ☐ No

What surgeries have you had? If so, please include the year. (Joint replacement, heart valve replacement, etc.)

____

____

Have you been told you have hypoglycemia, hyperglycemia, borderline blood sugars or pre-diabetes? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If so, what kind? ______________________________

Do you get frequent sinus infections? ☐ Yes ☐ No

Do you have any allergies? (Check all that apply).

☐ Codeine ☐ Gluten ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ None
☐ Other: ____

Have you ever had pneumonia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Have you been told that you stop breathing or choke/gasp in your sleep? ☐ Yes ☐ No
Do you feel rested upon waking? ☐ Yes ☐ No
Do you doze off during the day? ☐ Yes ☐ No

How many alcoholic drinks do you consume per week? _________ (*One drink= 1 beer or 5 oz wine or 1.5 oz hard liquor*)

Do you, or have you ever used tobacco products? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ Chewing Tobacco

If yes, __________ pack(s)/day Number of years __________ Year quit (if applicable) __________

Are you pregnant or nursing? ☐ Yes ☐ No

YOUR MEDICATIONS & SUPPLEMENTS Please list any medications and supplements that you currently take.

____

____

____

Do you take any blood thinners, prescribed or OTC?

☐ Aspirin ☐ Coumadin ☐ Garlic ☐ Fish Oil ☐ Plavix ☐ Warfarin ☐ None

☐ Other: ____

Do you take any medications for osteoporosis?

☐ Actonel ☐ Aredia ☐ Boniva ☐ Fosomax ☐ Reclast ☐ Zometa ☐ None

☐ Other: ____

Is there anything we need to know about your health that is not listed above? ☐ Yes ☐ No

If so, please share____

DENTAL HISTORY

Please check any of the following problems that apply to you.

☐ Bad breath

☐ Bleeding, swollen or irritated gums

☐ Broken teeth or fillings

☐ Grinding or clenching teeth

☐ Headaches, earaches or neck pain

☐ Jaw joint pain

☐ Loose, tipped or shifting teeth

☐ Sensitivity **Where?** UR UL LR LL

Do you have or have you had any of the following?

☐ Braces ☐ Periodontal (gum) treatments

☐ Dentures ☐ Partial Dentures

Please share the following dates:

Your last cleaning ______________

Your last oral cancer screening ______________

Your last complete set of x-rays ______________

Name of previous dentist: ______________________

____

City, State Telephone Number

Why did you leave your previous dentist?

____

____

What is the most important thing to you about your future smile and dental health?

____

____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐ Yes ☐ No

If I could change my smile, I would:

☐ Make them whiter ☐ Make them straighter

☐ Close spaces ☐ Repair chipped teeth

☐ Replace old crowns that don't match

☐ Replace metal fillings with tooth colored fillings

☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

____

____

____

Patient Signature Date

____

Provider Signature Date

Treatment Consent

I, ______________________________, authorize LifeTime Dental, Inc. Doctors and designated staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor(s) in order to make a thorough diagnosis of my dental needs. I authorize the Doctor(s) and designated staff to perform all forms of treatment, medication, and therapy that may be indicated in connection with my case or my dependent's case with my consent. I understand that the use of anesthetic agents embodies a certain risk. I authorize the Doctor(s) to employ such assistance as they deem fit.

Release of Information

I, ______________________________, authorize LifeTime Dental, Inc. to release my personal information regarding my diagnosis, proposed, pending and/or completed treatment, billing, insurance, records and to discuss matters relating to my care to the following individuals:

Name: _______________________________________ Relationship: ________________________

Name: _______________________________________ Relationship: ________________________

Name: _______________________________________ Relationship: ________________________

☐ No information is to be released to anyone.

***This Release of Information will remain in effect until terminated by me in writing.**

Patient Photo Release Form

This release is strictly designed to give permission to LifeTime Dental, Inc. to use my digital patient photos for their website, Social Media, and in office presentation for both educational and promotional purposes. Lifetime Dental Inc. will have permission to use these photos in the manner discussed with me, unless I request the office no longer use them. I understand that by allowing LifeTime Dental Inc. to use my photos, they are able to share "before and after" images to educate and explain procedures and possible results of treatment. I understand that I have the option to decline this request, and am not obligated in any way to provide permission to use these photos.

☐I will allow LifeTime Dental Inc. to share my digital patient photos.

☐ I am requesting that my digital patient photos **NOT** be shared.

Email

I grant permission to Lifetime Dental, Inc. to contact me via email. Correspondence may include appointment confirmations, newsletters, special announcements, and offers. **Note:** Privacy is very important to us! We will not share your Email address with anyone. At any point, you may "unsubscribe" link at the bottom of any email.

Signature: ____ Date: _____/______/______

Witness: ____ Date: _____/______/______

LifeTimeDental.us

Office/Financial Policies

Thank you for choosing Lifetime Dental, Inc. as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Please read the following policies and sign at the bottom to indicate that you understand the LifeTime Dental, Inc. Financial Policies to the best of your knowledge.

Dental Insurance

- In order for us to maintain a high level of service to you, we provide the courtesy of submitting your insurance claim on your behalf and supporting you with maximizing your benefits. Policy coverage, changes, and follow-up on unpaid claims is your responsibility. Please be prepared to show your insurance card at the time of your visit.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- If your insurance company has not made a payment within 90 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.)
- All **deductible and co-payment amounts**, which are the estimated amount not covered by your insurance company, are **due at the time of service**.

Payment Options

- 5% Discount on any treatment over $1000 if paid in full with CASH/CHECK.
- Our office accepts cash, personal check, MasterCard, Visa, American Express, Discover, Green Sky and Care Credit.
- CareCredit - If you need to make long term payments we can offer financing with Care Credit. One of our team members will be happy to help you fill out an application. You must qualify to use this financing option.
- We reserve the right to charge a **$35.00 fee on all returned checks**.

Payment Plan Options

- **Crown/Bridge:** 1st payment due at initial crown prep appointment and final Balance is due at time of crown/bridge delivery.
- **Denture/ Partial:** Payments can be made at each appointment for Impression, Framework, Wax Try-in with final payment in full at time of denture/partial delivery.

Delinquent Accounts

- After 90 days, all accounts that are not paid in full may be sent to a third party collection agency. We will charge your account for our collection costs if we refer your account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs.

Cancellation Policy

- Due to the fact that we are reserving time on our schedule for your appointment, we ask that you provide 48hrs notice for any appointments that you may need to cancel.
- All changes in your scheduled appointment should be handled during our normal business hours if at all possible. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist.
- Failure to follow the cancellation policy will result in a **$35 cancellation fee**.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize LifeTime Dental to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dental practice insurance benefits otherwise payable directly to me. I understand that my insurance carrier may pay less than the usual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name (Please Print): ____

Signature: ____ Date: ________________________

Acknowledgement of Privacy Practices

I,____, have received a copy of the Privacy Practices of LifeTime Dental.
Name (Please Print)

Signature: ____ Date: ________________________

For office use only:

We attempted to obtain written acknowledgement of receipt of our Privacy Practices but acknowledgement could not be obtained because:

○ Individual Refused to Sign
○ Communication Barriers Prohibited obtaining acknowledgement
○ An emergency situation prevented us from obtaining acknowledgement
○ Other (Please Specify) :____

Staff Signature: ____

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HIPAA PATIENT CONSENT FORM

Patient Name: ____ Date of Birth: _________________________

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or on our website at www.lifetimedental.us under the Patient Information tab.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: ____ **Date:** _____________________________

____ **Relationship:** _____________________

Print name (if other than the patient)

Witness: ____ **Date:** _____________________________